CALIFORNIA RURAL HEALTH POLICY COUNCIL
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California Rural Health Policy Council
Public Meeting Summary
May 25, 2004 - San Diego, CA

Council Representatives - present
Stephen Mayberg Ph.D. Director
Department of Mental Health (DMH)

David Carlisle, M.D., Ph.D., Director
Office of Statewide Health Planning and Development (OSHPD)

Richard Watson, Interim Director
Emergency Medical Services Authority (EMSA)

Betsey Lyman, Assistant Deputy Director
Department of Health Services (DHS)

Pablo Rosales, Interim Executive Director
California Rural Health Policy Council (CRHPC)

Council Representatives – absent
Department of Alcohol and Drug Programs (DADP)

Managed Risk Medical Insurance Board (MRMIB)

Council Staff
Kathleen Maestas
Kerri Muraki

Commenced: 9:15 a.m.

I. Call to Order - Introductions – Opening remarks
Dr. Stephen Mayberg – Council Chairperson

II. Centers for Medicaid and Medicare Services (CMS) Update
Ron Ho, San Francisco Regional Office

Changes to the Medicare Program enacted by the Medicare Modernization Act (MMA) of December 8, 2003.

Mr. Ho's Power point presentation can be downloaded at:
http://www.ruralhealth.ca.gov/pdf/RHC-FQHC Overview-CRHPC Meeting 5-25-04.Updated 6-11-04.pdf

III. RHC Eligibility Requirements and Certification Process in California

Konder Chung, Manager OSHPD Community Development Division
Update on shortage designations

OSHPD is responsible for the Cooperative Agreement funded annually from HRSA to determine Medically Underserved Areas (MUA), Health Professional Shortage Areas (HPSA) and is designated as the Primary Care Office for California.

Ms. Chung's Power point presentation can be downloaded at: http://www.ruralhealth.ca.gov/pdf/OSHPD RHC Eligibility Requirements 5-25-04.pdf

Added PowerPoint items:

- Technical Assistance: Three regional workshops are offered throughout the state. These are 2-day hands-on workshops focusing on the HPSA, MUA, and MUP process.
- MSSA designation is strictly for the State of California. CMS does not recognize our MSSA rural-frontier determinations for eligibility for rural health clinics.
- The state of California recognizes MSSA as a rational service area.
- RHC eligibility requires a Primary Medical Care HPSA
- CMS designations use only area and population. Facility does not apply.
- Updated website: http://www.oshpd.ca.gov/pcrcd/cooperative/index.htm this page now includes a link for HPSA designation updates.

Anthony Coletti, District Administrator, Department of Health Services – Licensing and Certification, Northern San Diego District Office

Donna Loza, District Administrator, Department of Health Services – Licensing and Certification, Southern San Diego District Office

To download Mr. Coletti and Ms Loza's presentation, go to http://www.ruralhealth.ca.gov/pdf/040525 RHC Licensing and Certification Application Process.pdf

IV. California Rural Health Policy Council Update

Pablo Rosales, Interim Executive Director

Rural Health Research Network Focus Group
The California Rural Health Policy Council was asked to participate as a data support mechanism for this group.

Data Dissemination
The CRHPC staff in collaboration with OSHPD's Health Information Division (HID) and Health Information Resource Center (HIRC), to access utilization and facility licensing data via OSHPD's ALIRTS website (http://www.alirts.oshpd.ca.gov/). Other available data such as healthcare data and reports for: Hospital, Long Term Care, Clinic, can be accessed through the HIRC catalog (http://www.oshpd.ca.gov/HQAD/index.htm).

Rural Jobs Available Service
This service is available for rural healthcare facilities to post their job vacancies free of charge on the CRHPC website http://www.ruralhealth.ca.gov/jobsavailable.htm. The CRHPC staff is currently working with the California State Rural Health Association, the Rural Design Network, and the State Office of Rural Health to submit a collaborative proposal to seek funding to develop a capacity to recruit and retain health professionals in rural California.

Rural Health Clinic (RHC) Eligibility and Certification Process in California:
Rural Health Clinic providers raised concerns related to CMS regulations dated December 24, 2003 regarding eligibility and decertification. The CRHPC staff responded to these inquiries by inviting representatives from each of the government agencies that are involved with the RHC process to a panel presentation on this topic.

VI. State and Council Department Updates

State of California Update
Stephen Mayberg, Ph.D.

State Budget:
Efforts have been made by Health and Human Service Agency to try and mitigate some of the proposed cuts and review our capability to maintain a healthcare infrastructure. Decisions revolve around the issues of access and eligibility. Currently, it has been decided that decisions shouldn't be driven by budget numbers, but by programmatic decisions. Proposals regarding MediCal reform will not submitted to the Legislature until August.

California Performance Review (CPR):
CPR is Governor Schwarzenegger's order to examine California's business practices by structure and process. Recommendations will be based on function, rather than cost. Initial reports release date - June 2004. Recommendations will be used as discussion points.

AB 2281 (Berg)
The administration is aware of this legislation. The administration makes position decisions on all legislative bills.

Department of Health Services Update
Betsey Lyman

The Department of Health Services houses the federally funded State Office of Rural Health. Rural has a central focus in DHS, and coordination on rural issues is very important to DHS.

Announcements:

- New Director, Sandra Shewry, formerly of MRMIB
- New Public Health Officer, Dr. Dick Jackson
- Child Obesity Conference - January 2005 in San Diego.
- MediCal redesign is ongoing
- *Budget*: State funding for the clinic programs, like the Seasonal and Agricultural Migrant Workers, Indian Health Program, the EAPC Program and others, at this point, they are intact on both sides of the House and in the Governor's May revision.
- *MediCal rate reduction*: the proposed 10% reduction is no longer in the budget
- *Proposed caps on enrollment*: Proposed caps have been eliminated for Healthy Families, California Children's Services (CCS), and other programs.

Emergency Medical Service Authority Update
Richard Watson

EMT Modular Approach
EMSA is responsible for overseeing and passing regulations for EMTs and paramedics in the State of California. An EMT 2 modular approach task force will be appointed, whereby EMT1s who are located primarily in rural; can focus on one modular area (like the heart) and be able to do more advanced services, (IVs) which currently require more advanced certification. Revision of the regulations would enable EMT 1s to provide those services.

Automated External Defibrillators (AED) Grant
3rd year of a $200,000 per year grant to provide AEDs and training for primarily rural fire departments, but also includes clinics in some cases.

New Trauma Centers in Rural Areas
Level IV Trauma Centers were not available in the rural areas. Seven new trauma systems are now available in rural areas such as Tuolumne, Alpine,

Amador, and Calaveras. Our aim is to have a trauma center within an hour of any accident site.

Emergency Communication Systems Grant

$1 million dollar grant was awarded for better communication for emergency vehicles. Emergency vehicles currently operate on difference frequencies and communication is delayed. We are attempting to get approval to own an emergency frequency in Imperial and San Diego counties.

CDC Grant

EMSA is responsible for about $38 million of a HRSA - CDC grant. We will be looking at rural clinics in terms of training, personal protective equipment/clothing, etc.

Web based patient reporting system (North Coast)

Paramedics or EMT 1s prepare hand written Patient Care Reports (PCR). In order to efficiently distribute these reports to hospitals, a grant is being developed to do this paperwork on-line on a web-based system.

Office of Statewide Health and Planning and Development (OSHPD) Update
David Carlisle, M.D., Ph.D.

Cal Mortgage Program

Moody's announced the elevation of the State's credit rating. This renders the Cal Mortgage Program, who helps finance non-profit health facilities, more competitive

MIRCAL Program

Data is now available through the calendar year 2003.

Song Brown Program will continue

VII. Public Comment

Randy Boone, Lindsey Urgent Care:
If a clinic is independently certified and would like to be provider-based certified, does the application process start from the beginning? The facility is certified independent (freestanding). This is kind of a hypothetical question. The clinic wanted to become provider-based in conjunction with a local hospital, does the certification process start anew? This is a kind of a hypothetical question that I was asked to bring to this meeting. I'm speaking more of a continued partnership.

Lauri Mederios, Executive Director, California State Rural Health Association

When and where will the next technical assistance workshops be?

We keep hearing there is an October 2004 deadline for this year's re-designations. Is that true?

I need to be clear, you can be certified as a rural health clinic and not receive reimbursement for Medicare at a rural rate. There are two different definitions that determine those certifications.

Konder Chung: Two technical assistance workshops were held in March 2004. November 2004 and March 2005 are target dates for upcoming workshops. Check our webpage for specific dates http://www.oshpd.ca.gov/pcrcd/cooperative/index.htm. Re-designation information and all the original applicants names are also listed on the web site.

Ron Ho: For information regarding rural health clinic certifications (See the CMS fact sheet for response.) http://www.ruralhealth.ca.gov/pdf/FACTSHEET.FQHC-RHC CERTIFICATION & REIMBURSEMENT.pdf

Ned Miller, CEO, Castle Family Health Center
We just hope very strongly that this organization is allowed to continue and things will pass to make that happen, even with the budget situation.

Concerns:

- *Cuts in rural health and FQHC reimbursement rates. We have heard cuts up to 20% on FQHCs and rural health clinics for reimbursement statewide*
- *Cuts on retroactive payments*
- *CMS regulation exceptions*
  CMS regulation exceptions do not apply to those considered urban by the federal definition of the census. We have 92% MediCal in our three rural health clinics we are not able to apply for an exemption since we have been designated as federally urban. The definition of the MSSA that has been established in California with the help of the federal government should be used for rural eligibility. I, along with folks from other states will work through our congressmen to make some changes in the regulations to protect rural health. They say this is a budget neutral process, if it is, then leave it alone. They should just give us who exist an exemption or a grandfather clause.

Gail Nickerson, Adventist Health hospitals in Hanford, Selma, Clearlake and Paradise, CA
When will the Notice of Proposed Rulemaking be issued?

Thank you for bringing representatives from CMS and DHS Licensing and Certification to the May meeting of the Rural Health Policy Council and thanks for hearing from the Rural Health Clinics, today.

Concerns:

- *New Hospital-based clinic certification/reimbursement*

Each of our hospitals has faced serious challenges in certifying and getting reimbursement for new Rural Health Clinics that have been opened over the last couple of years. Hospital-based clinics have not been included in legislation such as SB 937, which streamlined the application process for community and free clinics. We are waiting months for site surveys, weeks for letters of deficiencies (which are supposed to be sent within 10 days of the survey) and up to and sometimes more than a year for rate setting and reimbursement of back claims. Our system has borne the financial problems associated with these delays, but in some cases it has severely taxed the whole hospital's ability to continue to provide services.

- *SB 857*
  Our sites are regulated by SB 857, which was designed to prevent fraud and abuse among new MediCal providers, and allows the state up to 6 months to process applications. This regulation further impacts the hospital-based clinics.

David Botelho, Chief, Department of Health Services, Audits and Investigations, Financial Audits Branch

Reimbursement cuts

- 10% and 20% cuts - unaware of anything that DHS proposed
- Elimination of the alternative methodology in establishing a PPS rate
  The Department was asked for some cost savings proposals, in the clinic area specifically; the only issue that was raised was the elimination of the alternative methodology in establishing a PPS rate. It is not retroactive, it was perspective only and the latest proposal it would take effect October 2004. That was a perspective change only.

Clinic Reimbursement – Scope of Service
Many clinic's scope of service has changed since establishing their PPS rates. Meetings have been convened with the California Primary Care Association (CPCA), Mary Huttner of the California Healthcare Association (CHA), Clark Lowry & Koortbojian and CMS to discuss this issue. An agreement was determined on a methodology for calculating and processing scope of service changes. We refer to it as the AD20 method. Training was provided in February 2004.

Reconciliations for those visits where you don't get your full PPS rate
Managed Care - Code 18, crossover claims, and your CHDP claims. A two-page reconciliation form was sent out to all the clinics. Form summarization by type managed care, crossover, or CHDP and the payments received from them. Forms are being reconciled to the site's PPS rate you have for the different

points in time. Staff is processing those reconciliations, but no checks are being issued. No funding was placed in this current year's budget. (03-04 budget) Checks will not be available until the 04-05 budget is approved.

Code 18 rates
Rates were established in 1999 and 2000 based on the information provided by the clinics. Some site Code 18 rates are either too high or too low. To request rate recalculation forms, contact the DHS Audits Review and Analysis Section at 916-650-6696.

Judith Shaplin, CEO, Mountain Health and Community Services

Change from a RHC status to a FQHC status
My clinic changed September 1, 2002; currently waiting for the change of scope for a significant increase of reimbursement from an RHC to FQHC. A consolidated cost report was submitted, as instructed by DHS. We just received notification from Donna Shine that stated, that we now fall under the 2001 regs .for new clinics, even though we are not "new clinics", we are "new change of scope." We are now required to submit a separate type of cost report for our administration and DHS staff was unclear on the correct cost report to be submitted. DHS needs to clarify implementation based on practical operability. Sites need to get the increased rate in accordance with the regulations. We can't get through the bureaucracy to get it submitted. So we ask for your help in doing this. We don't expect an answer here. I'm just bringing it up again to let you know that this is an on-going issue.

Thanks DHS for receiving wraparound rates within three weeks of the last Policy Council Public Meeting.

Mountain Health is looking to opening a new facility in December, we were told we needed to start our application process now, because of the length of time it takes to process it. We know we have the interim 6-month provisional because of legislation passed last year. Then I was just notified, even though we had a provisional we do not receive our ability to receive our provider license number for reimbursement issues. Asking Mr. Ho, can we apply for something that was we have the address, but the facility is in the process of being built?

Colly Tettelbach, California State Rural Health Association (CSRHA)
I am speaking on behalf of CSRHA, this testimony was unanimously passed by the CSRHA Board and was also shared, yesterday by some of us with CHHSA (California Health and Human Services Agency) Secretary Kim Belshé.

We believe the continuing work and endeavors of the California Rural Health Policy Council (CRHPC) should be a priority for California, the current CHHSA Secretary and the administration. The role of the CRHPC should focus on leadership, advocacy and coordination of policy specific to rural healthcare. In addition, the CRHPC should continue to provide leadership and policy

recommendations to the CHHSA Secretary to ensure effective decision-making at the highest levels of government. CSRHA would like to acknowledge the positive efforts of the CRHPC even through these fiscally difficult and tumultuous times. The staff has been helpful and knowledgeable. We would like to see the CRHPC continue to provide the following key services: collaboration on policy issues and briefs on partner organizations at the federal, state and regional levels; sponsorship, participation and coordination at educational events, i.e. conferences, symposia with other rural organizations; facilitation of workgroups in important policy issues; make recommendations to the CHHSA Secretary about key outcomes and decisions.

Update on AB 2281:
It has bipartisan support and has been voted on in consent form in the Assembly Health and Appropriations Committees. It is expected to pass again, by consent, on the Assembly floor today.

Pablo Rosales: My only response is to say thank you for the continued support that we get from CSRHA. I hope we can continue the collaborative efforts and the services needed for rural California.

Betsey Lyman: I hope everyone in this room heard me say several times today that we continue to have tremendous support for rural health services in the DHS. We are looking forward to continue to work with you.

Lauri Mederios, Executive Director, California State Rural Health Association (CSRHA)
Can the CRHPC work once again with the California State Rural Health Association to analyze the impact of the proposed new ruling from CMS regarding the rural health clinic program and that we can collectively provide a policy brief and recommendations when those pubic comments are made available during that 90 day period?

James Lanas, Executive Director, Healthcare Resource Center
Question regarding rural health job services regarding the performance data, performance of services, and the 3R Net (National Recruitment and Retention Network) and what type of job placements and what type of settings they have been placed and what type of physician locations.

I have looked on both websites, and I have not seen any performance data regarding service, also I would also like to ask what dollars are budgeted for services.

Pablo Rosales: We don't carry a particular budget line item exclusively for this service; it incorporated as part of our overall operation costs. In terms of outcomes, we have had nothing but positive feedback from our community

providers that use this service. Initially we thought we could not participate with 3R Net, because of the lack of funding, but we were able work this out through a collaboration with CSRHA, the Rural Design Network and the California State Office of Rural Health.

Spreanza Avram, Executive Director, Northern Sierra Rural Health Network

Check-write delay for MediCal
The Northern California Rural Roundtable discussed concerns of the state cost saving proposal of a two-week check-write delay for MediCal. We understand that there is some flexibility in to how that check-write delay gets implemented. Providers were very concerned by having a one or two-week delay with no MediCal checks, some facilities can incur a financial burden in the hundreds of thousands of dollars. One Roundtable suggestion: DHS to consider calculating the estimated one week or two week delay savings actually implementing that over a one year period. So you are essentially doing a 1/52nd of the cost savings as way of helping the MediCal providers throughout the state. This is not just limited to clinics. This is sometimes a huge hit up to 60 to 80% of their budget and possibly not getting notified until 2 weeks before implementation, is a huge impact.

Betsey Lyman: Could I ask you to clarify your proposed solution?

Speranza Avram
Instead of taking $100 million dollars that you are not writing in one week, that is the savings in one period of time, basically take a little off the top of every check throughout the year. Basically it is the same amount of money. Its just not implemented all at one time. Instead of writing a $10.00 check, for example, write us an $8.00 check.

Meeting adjourned: 12:13 p.m.